CERTIFICATION OF HEALTH CARE PROVIDER

(Family & Medical Leave Act of 1993)

The information sought in this form relates only to the condition for which the employee is taking FMLA leave. Terms in **bold** are defined on the last page.

Employee Name	Patient's Name *(If other than employee)*

I. A *Serious Health Condition* means an illness, injury, impairment, or physical or mental condition, which under the Family & Medical Leave Act, is described by the following categories. Does the patient's condition qualify under any of the categories described?

☐ NO ☐ YES *If yes, please check the appropriate category below:*

☐ HOSPITAL CARE. Inpatient care (*i.e.*, an overnight stay) in a hospital, hospice or residential medical care facility, including any period of **incapacity** or subsequent **treatment** in connection with or consequent to such inpatient care.

☐ ABSENCE PLUS TREATMENT. A period of **incapacity** of more than three consecutive calendar days (including any subsequent **treatment** or period of **incapacity** relating to the same condition), that also involves:

- **treatment** two or more times by a **health care provider**; *or*
- **treatment** by a **health care provider** on at least one occasion which results in a **regimen of continuing treatment** under the supervision of the **health care provider**.

☐ PREGNANCY. Any period of **incapacity** due to pregnancy, or for prenatal care.

☐ CHRONIC CONDITIONS REQUIRING TREATMENTS. A chronic condition which:

- Requires periodic visits for treatment by a health care provider;
- Continues over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of **incapacity** (*e.g.*, asthma, diabetes, epilepsy, etc.).

☐ PERMANENT/LONG TERM CONDITIONS REQUIRING SUPERVISION. A period of **incapacity** which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active **treatment** by, a **health care provider**. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

☐ MULTIPLE TREATMENTS (NON-CHRONIC CONDITIONS). Any period of absence to receive multiple **treatments** (including any period of recovery therefrom) by a **health care provider** or by a provider of health care services under orders of, or on referral by, a **health care provider**, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of **incapacity** of more than three consecutive calendar days in the absence of medical intervention or **treatment**, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis).

II. Describe the medical facts which support your certification, including a brief statement as to how the medical facts meet the criteria of one of these categories:

_____

_____

_____

III. Describe the approximate date the condition commenced: _____

What is the probable duration of the condition: _____

What is the probable duration of the patient's present incapacity, if different: _____

Will it be necessary for the employee to work only intermittently or to work on a less than full schedule as a result of the condition (including for treatment described in item IV below)? ☐ NO ☐ YES If yes, what is the probable duration: _____

_____

If the condition is a chronic condition or pregnancy, describe whether the patient is presently incapacitated and what the likely duration and frequency of episodes of incapacity will be: _____

IV. If additional treatments will be required for the condition, provide an estimate of the probable number of such treatments: _____

_____

If the patient will be absent from work or other daily activities because of treatment on an intermittent or part-time basis, also provide an estimate of the probable number and interval between such treatments, actual or estimated dates of treatment if known, and period required for recovery, if any: _____

_____

If any of these treatments will be provided by another provider of health services (*e.g.*, physical therapist), please describe the nature of the treatments: _____

If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regimen (*e.g.*, prescription drugs, physical therapy requiring special equipment): _____

_____

V. If medical leave is required for the employee's absence from work because of the employee's own condition (including absences due to pregnancy or a chronic condition), is the employee able to perform work of any kind? ☐ YES ☐ NO

If able to perform some work, is the employee able to perform all of the essential functions of the employee's job? *(Answer after reviewing statement from employer of essential functions of employee's position, or, if none provided, after discussing with employee.)*

☐ YES ☐ NO If no, please list the essential functions the employee is unable to perform: _____

_____

If neither of the above applies, is it necessary for the employee to be absent from work for treatment? ☐ YES ☐ NO

VI. If leave is required to care for a family member of the employee with a serious health condition, does the patient require assistance for basic medical or personal needs or safety, or for transportation? ☐ YES ☐ NO

If no, would the employee's presence to provide psychological comfort be beneficial to the patient or assist in the patient's recovery?

☐ YES ☐ NO

If the patient will need care only intermittently or on a part-time basis, please indicate the probable duration of this need: _____

_____

Name, Address and Telephone Number of Health Care Provider:	Type of Practice - Field of Specialization:
	Signature of Health Care Provider:
	Date:

TO BE COMPLETED BY AN EMPLOYEE NEEDING FAMILY LEAVE TO CARE FOR A FAMILY MEMBER PRIOR TO SUBMITTING THIS FORM TO THE HEALTH CARE PROVIDER.

VII. Describe the care you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less than a full schedule:

Employee Signature:	Date:

DEFINITION OF TERMS:

Incapacity, for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

Treatment includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

A **regimen of continuing treatment** includes, for example, a course of prescription medication (*e.g.*, an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

Health care provider includes a doctor of medicine or osteopathy, podiatric physician, dentist, clinical psychologist, optometrist, chiropractor, nurse practitioner, nurse midwife, clinical social worker, a practioner in Christian Science who is listed with the First Church of Christ, Scientist, in Boston, MA, and a provider of health care as defined by NRS 729.031.